

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **36176**
Registrar's No. **9321**

FILED NOV 14 1952

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY LEMA	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) LEMA	
c. LENGTH OF STAY (in this place) 10 days		d. STREET ADDRESS (If rural, give location) Box 447 C	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital		4. DATE OF DEATH (Month) (Day) (Year) 10 7 52	
3. NAME OF DECEASED (Type or Print) KENNETH WILLIAM BEYES	a. (First)	b. (Middle)	c. (Last)
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH 7-9-51
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 14	11. BIRTHPLACE (State or foreign country) St. Louis, Mo
12. CITIZEN OF WHAT COUNTRY? U.S.	13a. FATHER'S NAME Frederick F. Beys	13b. MOTHER'S MAIDEN NAME Elizabeth Spahn	14. NAME OF HUSBAND OR WIFE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. No	17. INFORMANT'S SIGNATURE OR NAME B. B. Thompson 500 S. Kings Highway	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital heart disease ANTECEDENT CAUSES Heterology of Fallot DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21f. HOW DID INJURY OCCUR? 7540
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22. I hereby certify that I attended the deceased from 9-27-1952 to 10-7-1952 , that I last saw the deceased alive on 10-7-1952 , and that death occurred at 11:10 AM , from the causes and on the date stated above.	
23a. SIGNATURE John C. Herweg M.D.	(Degree or title)	23b. ADDRESS 500 S Kings Highway	23c. DATE SIGNED 10/7/52
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 10, 1952	24c. NAME OF CEMETERY OR CREMATORY Mount Hope Cemetery	24d. LOCATION (City, town, or county) (State) 1215 Lemay Ferry Rd. Lemay, Mo.
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE OCT 8 1952	25. FUNERAL DIRECTOR'S SIGNATURE C. Hoffmeister	ADDRESS U. & L. Co. 7814 S. Broadway	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Levin C. Hoffmeister

Licensed Embalmer No. *3821*

P. O. Address *7814 S. Brown*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.